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CONSULTATION REPORT

[redacted]

Date of Admission: 10/01/2012 Date of Consultation: 10/02/2012

HISTORY OF PRESENT ILLNESS: This is a 55-year-old white male with a history of hyperlipidemia and previous stroke who is referred for evaluation. I first met him in September 2011 when he presented with acute shortness of breath, diaphoresis, and vague chest discomfort. He had episodes of loss of postural tone and was subsequently shown to have a stroke based on an MRI. He underwent right and left heart cath. The coronaries are normal. Left ventricular function was preserved. There was a slight step-up in his oxygen saturation suggestive of PFO. Echo, in fact, confirmed a patent foramen ovale with preserved LV function and normal right-sided pressures. He presents now with similar symptoms where he suddenly becomes lightheaded, dizzy, and feels off balance. He has had some intermittent numbness and paresis of the right upper extremity associated with it. It has occurred twice in the last 2 weeks; generally will last less than 2 minutes. He has no dysarthria but he also states he has had dysphagia to liquids intermittently over the past 2 months. No cough, sputum production, chills, fever, melena, or hematochezia. He denies pain, pressure, or tightness suggestive of angina. No PND, orthopnea, pedal edema.

His coronary risk factors are notable for hyperlipidemia but no hypertension, diabetes, or tobacco abuse.

PAST MEDICAL HISTORY: No asthma, emphysema, kidney disease, liver disease, or strokes. He has had kidney stones. Known patent foramen ovale.

ALLERGIES: None.

HOME MEDICINES: Meclizine, aspirin, and Pravachol.

PHYSICAL EXAMINATION: VITAL SIGNS: 113/82, pulse 82, respirations 20. GENERAL: Well-nourished, well-developed white male. He is alert. He is oriented. He is in no distress. HEENT: Without thyromegaly, JVD, or carotid bruits. CARDIOVASCULAR: Regular rhythm. PULMONARY: Clear. ABDOMEN: Benign. EXTREMITIES: 1+ pulses.

Electrocardiogram shows sinus rhythm.

LABORATORY DATA: BUN and creatinine 8 and 0.8. CK and troponin are normal. Cholesterol 185, LDL 120, H and H 15 and 45 with a platelet

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count of 22. Telemetry is sinus rhythm.

ASSESSMENT AND PLAN:

1. Ataxia, vertigo, paresis and paresthesias. This really sounds more like a neurologic syndrome. The constellation of the symptoms suggest possible brain stem involvement but I will certainly defer that to the neurologist. The question to me is whether or not this could involve the patent foramen ovale. It is certainly a possibility. One option is to increase his antiplatelets versus add Coumadin but certainly closure of the PFO is another option but I would like to see what the neurologist has to say first.
2. Cardiovascular. I am really not getting a symptom complex that makes me believe he is having congestive failure or angina and with a recent normal angiography I think I would continue to follow.
3. Hyperlipidemia. His LDL is still over 100. Consider increasing the statin.

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CONSULTATION REPORT

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Date of Admission: 10/01/2012 Date of Consultation: 10/02/2012

REQUESTING PHYSICIAN: [redacted]

REASON FOR CONSULTATION: Worsened dizziness with a history of stroke.

HISTORY OF PRESENT ILLNESS: [redacted] is a 55-year-old, right-hand dominant, Caucasian gentleman with a history of hyperlipidemia and chronic vertigo after a stroke 1 year ago. He was found to have patent foramen ovale, though was determined closure was not necessary at that time, and he was to be taking home aspirin, statin and meclizine for his symptomatic management of his vertigo. Apparently, he has had a 3-day history now of acute worsening of his dizziness. He states that there is no associated symptom without alleviation from meclizine. He denies any aggravating factors. He has had a computed tomography (CT) scan of the head without contrast since admission, which was negative for any acute findings. [redacted] denies any change in his home medication regimen, or any recent fever, chills, shortness of breath, nausea, vomiting, diarrhea, dysuria or change in home environment. He does state that he is in line for a right hip replacement within the next month. Neurology consultation now is requested to further evaluate the acute worsening of his dizziness.

PAST MEDICAL HISTORY:
1. Stroke in October 2011 with resultant vertigo.
2. History of hyperlipidemia.
3. History of patent foramen ovale.
4. History of left hip replacement in 1997, repeat in 2010.
5. History of kidney stones.
6. History of bulging L5 disc.

ALLERGIES: No known drug allergies.

HOME MEDICATIONS:
1. Meclizine 25 mg per mouth three times a day.
2. He is not currently on aspirin or statin therapy, reason unknown.

SOCIAL HISTORY: He lives in [redacted] with his wife of approximately 35 years. He is a lifelong nonsmoker. He drinks approximately 1 beer a week, and no use of illicit drug use. He works as a machinist, 40-50 hours a week.

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FAMILY HISTORY: His father has a history of coronary artery disease with quadruple bypass. His mother has diabetes, type 2.

REVIEW OF SYSTEMS: A 14-point review of systems was completed and other than stated in the history of present illness, negative otherwise.

PHYSICAL EXAMINATION: GENERAL: [redacted] is seen sitting up in his bed. He is alert, oriented and appropriately conversive, in no acute distress. VITAL SIGNS: Afebrile at 97.8. Heart rate is 63. Blood pressure is 110/85. Respiratory rate is 20. Oxygen saturations are 96% on room air. HEENT: Normocephalic and atraumatic. No ptosis or masses. Hearing acuity is intact. HEART: S1 and S2. No S3, rubs, gallops or murmurs. No auscultated carotid bruits. LUNGS: Bilaterally clear to auscultation. No use of accessory muscles on examination. ABDOMEN: Soft, non-distended and nontender with normoactive bowel sounds. No hepatosplenomegaly noted with palpation. EXTREMITIES/SKIN: He has palpable pulses times 4 extremities. No apparent cyanosis, clubbing, edema or rash. NEUROLOGIC: Mental Status-He is awake and alert. He is oriented to person, place, time and circumstance. He follows commands without delay. Speech-Clear and fluent with intact comprehension and recent memory. Cranial Nerves-Extraocular movements are intact. Pupils are equal, round and reactive to light. Visual fields are full. Facial sensation and strength are equal bilaterally. Tongue and uvula are midline without abrasions. He has no noted dysarthria, no difficulty swallowing. Sensory-Intact to sensation and light touch without extinction. Musculoskeletal-Normal tone and bulk. No drift. Coordination-Normal finger to nose and heel to shin coordination bilaterally. No tremors noted at rest or with intention. Gait and station-Not observed. Strength-Strength is 5/5 throughout with exception of his right lower extremity, which is 4+/5 with some pain-limiting factor, with advanced right hip arthritis with plans for right hip replacement within the next month. Deep tendon reflexes are 1+ throughout. Plantar responses are bilaterally mute.

DIAGNOSTIC STUDIES: These were independently reviewed. CT scan of the head without contrast was negative. He has carotid dopplers and electrocardiogram (EKG) ordered.

LABORATORY DATA: Sodium is 138. Potassium is 3.6. Chloride is 102. CO2 is 24. BUN is 8. Creatinine is 0.8. Glucose is 89. Calcium is 9.5. White blood cell count is 5460. Hemoglobin is 15.4. Hematocrit is 45.1. Platelets are 221,000. LDL is 120. TSH is 2.31. Urine drug screen is negative. INR is 0.9.

ASSESSMENT AND PLAN: [redacted] is a 55-year-old gentleman with a history of hyperlipidemia, stroke and patent foramen ovale, who has resultant vertigo from his stroke 1 year ago. Apparently, he has been prescribed aspirin, Plavix and statin therapy, but is only known to be taking his meclizine. He also has a known history of anxiety with concern for possible panic attacks in the past. He has had a 3-day

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history of worsened dizziness with a non-focal neurologic examination. Concern at this time is for possible acute stroke versus transient ischemic attack (TIA).

1. We will plan MRI scan of the brain, without contrast.
2. Transcranial Dopplers.
3. Carotid Dopplers.
4. Continue aspirin, Plavix and statin therapy.
5. Fall precautions.

We appreciate the consultation on [redacted] and will ask [redacted], his primary neurologist, to follow up with him later this afternoon or tomorrow morning.

The above history, physical examination, assessment and plan was that of [redacted]

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DISCHARGE SUMMARY

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Date of Admission: 10/01/2012 Date of Discharge: 10/04/2012

ADMITTING DIAGNOSES:

1. Dizziness.
2. History of cerebrovascular accident 1 year ago with no residual weakness.
3. Hyperlipidemia
4. Patent foramen ovale.
5. Nephrolithiasis with lithotripsy in the past.
6. Left hip replacement x 2 and hip pain

DISCHARGE DIAGNOSES:

1. Dizziness probably secondary to vasovagal presyncope.
2. Panic anxiety disorder.
3. History of cerebrovascular accident 1 year ago with no residual weakness.
4. Hyperlipidemia.
5. Patent foramen ovale.
6. Nephrolithiasis with lithotripsy in the past
7. Left hip replacement x 2.

HISTORY OF PRESENT ILLNESS AND HOSPITAL COURSE: The patient is a 55-year-old white female with a past medical history of cerebrovascular accident, frontal ischemic stroke 1 year ago and hyperlipidemia, who presented with 6 months to 1 year history of sensation of dizziness and lightheadedness lasting 1-2 minutes that occurred 8 times a day and has happened more frequently in the last few days. Episodes occur usually when he gets up from a seated position and not associated with any changes of the position of the head, and he does not have it when he is walking around. He denied any palpitations, diaphoresis, shortness of breath, or any weakness associated with these spells of dizziness. The patient was previously admitted for complaints of dizziness and shortness of breath and was extensively worked up by cardiology. Cardiac catheterization and echocardiogram performed at that time was normal except patent foramen ovale, but it was not significant and no intervention was performed. The patient had also tried meclizine once, but it did not help him much. Therefore he did not take it any further. He was not taking any medications because, as per the patient, the patient medications were not helping him. Therefore, he was not taking even his aspirin and prevastatin. The patient also admits to having short episodes of shortness of breath that he usually gets at rest. It was not associated with any palpitations or sweating or chest pain and lasts for a short while and he does not have any shortness of breath on exertion. While in the hospital, the patient was worked up for his dizziness. CT head performed did not show any new abnormality or

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stroke. Carotid imaging performed was within normal limits. Transcranial Doppler performed did not show any stenosis of the cranial vessels. MRI of the brain did not show any new abnormality, no acute stroke. Echocardiogram performed did not show any abnormality. There was no telemetry events noted. [redacted] of neurology was consulted. [redacted] of cardiology was also consulted. The patient was started on aspirin and Pravachol and compression stockings were also applied and then the patient was started on midodrine. This helped the patient somewhat with his dizziness. All the workup was essentially negative and the patient subsequently improved and the patient was discharged home.

DISCHARGE MEDICATIONS:
1. Paxil 20 mg p.o. daily for his symptoms of anxiety or panic attacks.
2. Midodrine 5 mg p.o. t.i.d.
3. Aspirin 81 mg p.o. 1 tablet p.o. daily.
4. Pravachol 40 mg p.o. 1 tablet p.o. daily.
5. Compression stockings.

DISCHARGE DIET: Regular.

DISCHARGE ACTIVITY: As tolerated.

DISCHARGE DISPOSITION: Home.

As the patient has a history of benign prostatic hypertrophy, he was advised if he gets any urinary retention with midodrine, he was advised not to take the night dose of midodrine and if he cannot tolerate it, to stop the midodrine.

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